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ABSTRACT

Described is an adoption agency for difficult to place handicapped and older children (infancy through 16 years-old). The process involves initial assessment of the child's functioning and of the family's parenting capabilities, and continued support after placement. Placement histories of two handicapped children are presented. Reviewed are the adoption implications of blindness, cerebral palsy, cleft palate, deafness, diabetes, mental retardation, perceptual handicaps, and spina bifida. (CL)

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Older and Handicapped Children

Are Adoptable:

The Spaulding Approach

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CONTENTS

Letter of Explanation..... 1.

An Introduction to Spaulding for Children..... 2.

Placing Children ..... 5.

- Finding Families ..... 6.
- Evaluating Children ..... 8.
- The Mechanics of Placement .... 10.
- Post Placement Services ..... 14.
- Adoption Disruption ..... 16.

Some Particular Children ..... 18.

- Marty ..... 19.
- Jean and Kathy ..... 24.

Common Handicaps and Their Implications ..... 28.

- Blindness ..... 29.
- Cerebral Palsy ..... 29.
- Cleft Palate ..... 30.
- Deafness ..... 30.
- Diabetes ..... 31.
- Mental Retardation ..... 31.
- Perceptual Handicaps ..... 32.
- Spina Bifida ..... 33.

Resources ..... 34.

SPAULDING
FOR CHILDREN

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Since Spaulding for Children began work as a specialized adoption agency in 1968, more than 150 older and handicapped children have been placed with adoptive families in Michigan by this agency alone.

We believe these children are indeed able to be adopted and that there are families who can successfully parent them. Our hope is that this handbook, a brief summary of our beliefs and practices, will encourage other attempts to increase adoptive placements of similar youngsters.

The Spaulding Staff

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AN INTRODUCTION TO SPAULDING FOR CHILDREN

Spaulding for Children is a private or voluntary adoption agency, established as a result of citizen belief that many children labeled "hard-to-place" were not finding their way to permanent families. Spaulding for Children would not have been possible without the concern of Warren Spaulding, an 84 year old bachelor farmer, who gave his centennial farm and the surrounding acerage as a gift to be used for the benefit of children in his lifetime and beyond.

During the time that Warren Spaulding was looking for a way to help children, a seminar entitled Frontiers in Adoption was held at the University of Michigan. This meeting was jointly sponsored by the Council on Adoptable Children (an organization of adoptive parents, prospective adopters, and some professionals), the Michigan Association of Children's Agencies, the Michigan Department of Social Services, the Probate Judges' Association, the University of Michigan School of Social Work, and others. Frontiers in Adoption, held in 1967 and spearheaded by the Council on Adoptable Children, revealed that the rapidly increasing numbers of hard-to-place children were not receiving adequate attention and service. As a direct result of that conclusion, Spaulding for Children was founded to serve only the hard-to-place child: the youngster whose own special adoption needs made him less likely to find a permanent home. In 1968, the special needs factor was age or length of time without a permanent home, a physically or mentally handicapping condition, or minority heritage. For many children, a combination of two or more of these factors existed.

After operating as a specialized adoption agency from 1968 until the present, Spaulding for Children remains convinced that permanent adoptive families can be found for children who are older or handicapped. This process consists of staff workers preparing children for adoption, recruiting and preparing adoptive applicants for parenting these children, and remaining available to provide services to families even after the placement.

THE PHILOSOPHY

Spaulding believes that a child without legal family ties needs the permanency that adoption can provide. Spaulding believes that homes can be found for most of these children. Investigation of family background does not reveal if families have parenting abilities. Therefore, the adoption process should not be based on a rigid formula of obtaining family information. Spaulding focuses on assisting a family to accept a child with very special needs into their home. Spaulding makes every effort to find families who are willing to make an investment in a child who has been filled with insecurity and confusion. Working together, the family and the worker will identify the contributions which the family can offer the older or handicapped child. The process moves at a pace which enables a family to understand, accept, and eventually parent a child often unfamiliar with a sound family environment.

SPAULDING YOUNGSTERS

Spaulding has placed children ranging in age from early infancy through 16 years. The children share a common history in that the agency having their legal custody has been unable to find an adoptive family for them. Many have drifted from foster home to foster home over a period of years, and will continue to drift unless a permanent family is found for them. Increasing numbers of agencies have referred their waiting youngsters to Spaulding and have learned that such children can find their way to permanent families. Our success has encouraged them to find adoptive families for their other waiting children. Thus increasingly older and more seriously handicapped children are referred to Spaulding each year.

Many of the children referred to Spaulding are permanent wards of the various county probate courts or wards of the state. In these cases, family ties have been severed by legal action due to parental neglect or abuse. However, some children are referred to Spaulding by voluntary agencies after being "released" or "surrendered" for adoptive planning. (These are often handicapped children for whom the referring agency has no available family.)

THE PROCESS

Once a child is referred to Spaulding for Children, the staff evaluates the child as fully as possible, assessing future functioning and possible problems the child may encounter. If there is no waiting family available, newspaper recruitment is used to locate potential families for this child and for similar children. Workers talk with each responding family. They help families evaluate their own parenting capabilities in relation to a specific child; they do not determine who should be "accepted" or "rejected."

After locating an appropriate family, the worker and family discuss at length the child's history and the potential rewards and problems in placement. At all times, families are encouraged to discuss doubts and fears openly. Mutual decisions to proceed, shared between worker and family, are made throughout the process. A series of showing and visits help prepare the child and family for a permanent move. Parents are also prepared for adoption by meeting other families who have adopted children with similar handicaps. These families often form solid ties and have proved to be of great help to each other after placement.

After the child is placed with the family, Spaulding offers continued help to the family, both individually and in groups. Many Spaulding families remain in close contact with their workers well beyond confirmation. Some families ask for the agency's help over the years as problems occur. Because most families become acquainted with more than one worker during the process, staff turn-over need not interrupt the tie between family and agency. In fact, the Spaulding staff works as a team in understanding families and children, in making all placement decisions, and in sharing responsibility for providing services to families.

Adopting families are charged no fees. However, the family is asked to pay Court filing costs of under $75. Those agencies referring children to Spaulding for placement are asked to defray a portion of the cost of placement if the child is adopted. Spaulding undertakes to raise the remaining portion of the placement cost through its own fund-raising activities (i.e., the Child-of-the-Month Club, Spaulding memberships, foundation grants, an annual holiday card sale, etc.). Spaulding exists because of the genuine concern and commitment of staff, Board, volunteers, service clubs, civic groups, and individuals who recognize the need for an agency serving only older and handicapped youngsters. The agency has a single purpose: to find permanent families for these waiting children.

PLACING CHILDREN

FINDING FAMILIES

Families who adopt older or handicapped youngsters are not some form of exotic faunae found in remote forests. They are all around us, camouflaged among the ordinary people quietly going about the business of living. A social worker interested in placing children generally described as "hard-to-place" (a term that more describes the services offered these children, rather than the specific characteristics of the children themselves), would begin by a reexamination of the intake policies of the adoption agency.

After several years of working with families adopting older or handicapped children, a few observations come quickly to mind. There are still many common misconceptions about adoption and the adoptable child which are widely "known" by the general community. This folk information is commonly based on rumored adoption practices of the past decades and personal responses to parent/child relationships. People persist in believing that orphans abound in the country, that babies are still left in baskets on doorsteps, and that social workers are fastidious, middle class ladies in sensible shoes always on the lookout for dustballs under the bed. Attempts to correct the image of the children available for adoption appear to fail at first. Invariably, citizens read newspaper items on the older children who do need families and still believe that "older" means a slightly aged infant.

The problem encountered when trying to educate the community is that most change comes slowly for human beings. Social workers attempting a real change in public perception must embark on a planned campaign to alter the climate of the community. It is this plan we call COMMUNITY EDUCATION. This is best accomplished by sharing ideas among informed people who can then decide on a carefully established plan involving mass media (radio, television, newspapers, and magazines), clubs, organizations, service groups, churches, bowling leagues, and anyone else interested enough to learn. The effort should focus on telling the story of the children who wait, not necessarily on recruiting families for these children-- that is yet a separate issue. If we are to change the folk information available to prospective families (and to the community at large which will after all one day welcome these children and their new families) we must expect it to be a gradual process.

Apart from community education, the agency having the responsibility for planning for older or handicapped children must determine that true permanency for the child is the goal of service. Through the years, many agencies have experimented with various forms of permanent foster homes for children. Most such plans result in guarantees for the foster family, but few guarantees for the child.

Permanency for the child who cannot be returned to his own family must be produced through the establishment of legal ties which are an acceptable substitute for those biological ties now lost to him. Adoption is the alternative which most consistently meets the requirements of the majority of waiting children. But adoption is not a realistic goal unless community

education is underway and a total reexamination of the way in which the agency promotes inquiries and works with applicants is undertaken.

It is important that the agency image be an open and honest one and that the staff be friendly, enthusiastic social workers interested in children and eager and able to talk with all kinds of people about caring for children. Without that kind of atmosphere, success is impossible. But the public image must be affirmed by the private performance. The person answering the telephone must be warm and helpful. Letters must be promptly answered and the responses appropriate. Meetings must be comfortable and thoughtfully scheduled. Appointments must be at mutual convenience. The process must be streamlined, the paperwork minimized. Contacts between worker and family should result in more understanding of adoption, of experiences typical to families who have already adopted older or handicapped youngsters, of one another's assets and liabilities. Experienced adopters should be included in the process. They not only convey more believable information, they also can advise the applicant family about the services of the agency, the dependability of staff, the routine details the social worker may have forgotten or never learned.

Supportive services throughout the placement process and well beyond must be freely offered, the certainty of some problems of adjustment accepted. There should be a shared responsibility for the placement of a child. By eliminating as much as possible of the traditional "game-playing" of adoption (if they answer an appropriate question with an appropriate answer enough times in succession, they are rewarded with a child), we try to reach a position where mature people, having learned a great deal about themselves and the children available for adoption, make a decision to proceed into placement with the assistance of an agency they trust. Sweeping away our preconceived notions of a typical "acceptable" family is imperative. The new families coming to us should be old, young, and in-between. They should have comfortable incomes or be barely managing. They may have different levels of motivation; they may be well educated or semi-literate. Their only common trait must be the capacity to care for a child not born to them. Some will feel the impact of instant parental love. Some will remain the constant caretakers of a child needing care. Some will find adoption more than they dreamt it might be. Others will find it far less than they anticipated.

This method of working with applicant families, often called the "educative" approach to adoption (in opposition to the more traditional "investigative" approach), seems to be the logical choice for forming ties between family and agency and for permitting assistance and information to flow freely between the two for years to come. Families may well need the support and assistance we can offer. We certainly need the opinions and observations they have to offer. There is so much more we must learn about the new face of adoption.

EVALUATING CHILDREN

Children available for adoption, of whatever age and whichever characteristics, require families able to view them first as children and second as children of a particular developmental level and with individually distinguishing characteristics. The children who wait longest for adoptive placement are often youngsters categorized by adults who work with them as "difficult" or children who are traumatized by prolonged struggle with the thorny issues of parental rights and responsibilities. To move such a child to a permanent adoptive family requires much thought and sensitivity on the part of the child welfare staff if the child and the family are to have the greatest possibility of making a satisfactory adjustment to one another.

In order to find the best family for a child, the child must be known and a composite picture of his history and his current functioning has proven to be the most helpful tool. In exploring the child's true status, a variety of people are needed to provide essential information: the social worker or child care staff who know him best, the foster parents most familiar, the school teacher of longest duration, and the child himself. All of these individuals should be seen and their feelings and observations about the youngster carefully considered. (At the same time, the worker should be collecting information about how helpful these same people may be in helping the child move toward a new family. This is an especially crucial issue with the child's social worker and the foster parents or child care staff. During a move, these people will either be a help or a hinderance.)

In addition to personal contacts with people very important in the life of the child, it is important that the placement worker assess the child himself: to verify the impressions of others, to determine how much understanding the child has of his separation from biological family, to begin making a judgment about WHO will work with the youngster to the point of placement, WHEN he might be readied for placement, and WHAT KIND of family might be most comfortable for him.

The composite picture cannot be completed without careful scrutiny of all written records on the child and/or his family of origin. Workers must realize that records are notoriously sparse but also realize that they are the earliest (and perhaps your best) opportunity to construct the connection from past to future which will grow in importance as this child faces change and the deep need to know and understand what is happening to him. His history of moves from placement to placement (not just the dates, but the who and why of the move), the recorded or recalled information of staff who might have had contact with his family members, photographs if unearthed, descriptions, names, birthdates, can all be pieced together if the placement worker is persistent. In many respects it is like working on a vast and fascinating puzzle, but its completion will help you know this child and help immeasurably in making crucial judgments just ahead.

The placement worker can also be comforted by knowing that the material being collected will not be just discarded after placement of the child. This information will help the adoptive family understand the child's behavior in many instances. It will provide the newer family with greater insight into the old family and give them the material which, skillfully used, can assist the child with developing a more mature understanding of his own history as the years go on.

The composite picture, well drawn, includes the good as well as the bad, the attractive as well as the unattractive-- a full range of perspectives and possibilities, carefully identified. When a placement worker presents basic information on an available child to a prospective adoptive family, there should be a careful explanation of this range of perspectives and possibilities, rather than a categorical description that amounts to "this is the way he is." Given our still fairly primitive understanding of human personality and development, and our unquestionably poor powers of communication, categorical statements are extremely dangerous. The wise placement worker realizes that many children never perform in a new home the way they characteristically performed in the previous one. The damage done earlier in life to these children often precludes their responding to a newer, healthier family situation in the way we might hope. Love does not, and will not, cure all. A new family often simply provides different buttons to press. The placement worker who describes the past in factual terms and speculates about the future with realism gains in credibility.

THE MECHANICS OF PLACEMENT

The actual placement of a child into an adoptive family is an exciting experience-- for child, family, and worker. In the midst of such excitement it is often difficult to remember that serious pieces of business must be going on or the placement may well be just another move into deeper jeopardy for the child without parents. It is essential that the placement worker have the most comprehensive and accurate picture of the child's present functioning and be able to make some reasonable predictions of the child's future. Most adoptive families seek this kind of assurance of competency from the placement worker. To compose an accurate and comprehensive picture of a child, it is imperative that a placement worker have direct and personal contact with the child to be placed. (There are a few exceptions-- mostly involving international placements or placements occurring across vast geographic areas. Even here, however, the use of still photos, home movies, videotapes, tape recordings and thoughtful letters and telephone calls may prove indispensable in bridging that knowledge gap.) Aside from this personal contact, hopefully carried out in a setting designed to make the child as relaxed and normal as possible, it is equally imperative that the placement worker have access to people dealing with the child on a 24-hour basis. Contacts with foster families, school teachers, physicians, therapists, child care staff, and other persons in close personal contact with the youngster, must help develop that composite picture of current functioning that is necessary if the placement worker is to help the prospective family understand WHO the child is and HOW he became that person. A close working relationship with the foster care worker both enhances the placement worker's job and enables that foster care worker to share in the rewards of seeing the child achieve permanency.

Once the information is in hand, the placement worker makes a PRESENTATION to the prospective adoptive family. Although this can take the form of a fairly informal exploration of how the family might feel about a specific kind of child, it must always result in a carefully scheduled social worker/family interview with written records on the child and photographs recently taken. In all cases, the style of the presentation will depend upon the style of the family, the style of the placement worker, and the relationship between family and placement worker. The worker frequently gives the family copies of those parts of the record which would be most helpful in understanding the child. (This is done to provide a shared base for further discussion and to assure the family that they have access to all the information on the child they are considering.) The worker helps the family by sharing her past experiences with other adoptive placements and by cooperating with the family in seeking educational and medical resources the child will need. (A visit to a local special education classroom, for example, by the family considering a slow child; verification of the availability of medical treatment and funding programs by the family considering a physically handicapped child.) The worker also helps the family discuss their own experiences with people who have characteristics or handicaps similar to the child under consideration.

Many times, the worker who best knows the child and the worker who best knows the prospective family will team up to explore possibilities with the family. Even when dealing with a very open family group, it is often wise to not include the children of the family in this particular meeting. This will eliminate the possibility of the children feeling guilty about a decision not to continue consideration of a particular child.

Once the placement worker has a clear signal of the family's interest in a particular child, a SHOWING is arranged. Showings can be either "blind" or "known." In a blind showing, the prospective family is able to see the child, sometimes even talk with the child (in a suitably public or semi-public setting), but the child is not yet aware of the family's interest. Agencies often use this "blind showing" to avoid the possibility of the child committing himself to a particular family before they are ready to commit themselves to him or her. In a "known" showing the child and the prospective family are equally aware of each other and their mutual interest in adoption. The particular method employed by the placement worker may be related to the age of the child, the commitment exhibited by the prospective family, or any other factors which hold serious import in establishing new family ties. Such decisions should not be made by one single worker, nor should any fixed agency policy be followed in each and every case. Many children are left waiting for a family because of the limited vision of an individual social worker.

The prospective family should be given adequate time to consider their next step very carefully. The placement worker can best judge their initial response to the youngster by talking with them openly and freely soon after the showing. The decision to proceed to the next step is crucial because it involves preparing the child to meet them as prospective parents. A placement worker must also make a judgment as to how adequately the child has been prepared to meet a new family. Has the child's worker known the youngster long enough or well enough to help make the transition to a new family? Has the child received help in understanding and accepting his own separation from his original family (the biological family)? Has the foster family enough commitment to the child to help make the move to a new family a positive step in life? If the child's worker is unable to help with this phase of the placement activity, the placement worker should delay any further placement plans until this initial preparation is accomplished. The child's ability to become part of a new adoptive family will often be determined by the skill of the persons (foster parents and social workers) who help him understand his own history. The prospective adoptive family will continue the process of helping him understand and accept this past but they should not be expected to handle the total situation without the crucial beginnings made by other significant people in the child's life.

After the decision to continue is made, a MEETING is arranged. The social worker's role here is to assist all parties in feeling as comfortable as possible in meeting unknown people who may become the most important figures in each others' life. The youngster should be given understandable information about the family: photographs and anecdotes that best demonstrate what to expect. The timing of this information is important. Child-

ren measure time differently than adults. Several days become an interminable length of time. The meeting should be informal. Suggesting a family activity such as picnics, trips to a park or zoo, a few hours spent walking, playing and/or eating are often helpful. Family and child should be able to spend this time alone. If the social worker must participate (as with a very fearful, younger child), the worker's participation should be minimized and gradually eliminated altogether. The meeting is between parent and child, not between parent and social worker.

Following this meeting, the family and social worker should decide about proceeding further. While not expecting an absolute commitment at this point in the process, the worker should be alert to the seriousness of the family's intentions. There is a risk of damage to the child once the family indicates interest. What if the family later decides this is not the right child for them? What if the child cannot become part of this new family and makes that abundantly clear? But what if this child has no other possibilities for placement? The element of risk will always be present and it is the worker's responsibility to weigh that risk against the possible advantages to the child and family.

If the family and the social worker decide to continue, a series of visits must be planned. Depending upon the age of the child and his or her readiness to move to a new family, these visits may range from a few days in succession to several weekends in a series.

The worker who is alert to the questions and issues arising during these visits may make a successful placement possible during this period. Families are often too excited during the presentation and showing to make much sense out of the information provided by the placement worker. Children "honeymoon" during the initial visits and the reality of a normal behavior pattern may be long in emerging. It is wise to review the total situation between parent and child during these visits to correct information, explain behavior and help the family and the child move toward making a legal commitment to one another. The actual placement is the culmination of this entire process and comes only after the legal filing of the Adoption Petition, the gaining of the Consent and the Order of the judge. The placement also marks the beginning of the post-placement period-- the portion of the process considered by many placement workers to be the most crucial. However, what happens after placement is dependent upon what has gone before. The beginnings the child experienced, his growing awareness and understanding of his separation from the biological family, the sense of trust or lack of it he has developed, the skill of the worker who knew him best, the skill of the placement worker who helped join child and new family, must at all times be viewed as crucial to the future of the child.

Good placement work is a developed skill. A curious blend of warmth and feeling, judgment and sensitivity, make a good placement worker. Scholarship has little or nothing to do with it. Openness to the needs of the child, the situation of the family, has everything to do with it. Risk is always part of the job, but risk must be balanced by cautious, shared judgments. Pain is part of the job, because it is not possible to deal with the realities of a parentless child's history without pain. Over time,

a good placement worker develops skill that can help a family make the crucial adjustments to one another. Hard and fast rules of procedure will not help. Understanding will help and so will a commitment to the most secure and permanent placement available to each child in turn.

* In some states, the legal process follows the actual placement of the child with the prospective family. However, Michigan law requires that the legal process precede the actual placement of the youngster.

POST PLACEMENT SERVICES

Just as adjustments follow honeymoons, they also follow adoptive placements. Families ill-prepared for adoption usually discover (to their dismay) that adjustments are required of both parents and child. The skilled worker who has developed a warm and open relationship with the family and taken the time to know the child and his history, is in the best possible position to be of assistance to the adoptive family.

Some families are open to services and communicate this clearly-- even almost eagerly. Here the worker's chief problem may be to keep their expectations within bounds. The worker can provide support, can help them analyze and sort problems, can suggest solutions or direct them to resources, but the worker cannot solve every problem or explain every situation. Some families are much less eager to signal the need for service. This may be because their relationship with the worker is more tentative, or because they are embarrassed at not having anticipated the need for such help, or simply because their style is such that they do not find it easy to ask for assistance. The experienced worker anticipates this and will try to prepare the family to receive any necessary help even before placement. This is accomplished by reminding the family that this will be a unique situation just as each child is unique. Families tell us that placement workers tend to be the most interested and faithful listeners. Neighbors grow weary of parent/child stories and friends expect one to listen to their parent/child stories too. The social worker's interest is constant and reliable.

It is usually helpful to remain in close contact with a new adoptive family. This does not mean constant home calls. It may well mean telephone calls or even an occasional written note. Repeated contacts signal the family that the worker is interested and available. (The worker should take care that the calls or contacts are equally as assuring in nature as they are inquiring.) These contacts help the worker make a judgment as to how much help the family may need and want. It is often helpful to schedule a home contact within a few weeks after initial placement to review the presentation material again in the light of the parents' current experience with the youngster. Many parents remember little or nothing of the presentation material because of their excitement at learning of the availability of a particular child. It is only after living with that child for a while that some parts of the placement worker's information takes on shape and meaning.

Typically, new adoptive families may need assistance in enrolling a school-age child in the new school, or in gaining admission to a special classroom situation. They may need help in choosing a doctor or dentist for their new child, in applying for medical insurance or benefits, in getting information about parents' groups, or in joining organizations established to help parents of similar children. New adoptive parents may need to again review the information they will provide family and friends about their child and his history. They will also need to be prepared to help their youngster grow in his own understanding of separation and adoption.

Some agencies offer parents a variety of services in groups. Adoptive parents can often better help other adopters more than any social worker. If the worker can offer some broad predictions of <u>when</u> a family might wish assistance, it often makes it much easier for families to ask for help. We know, for example, that children entering school for the first time are often questioned by other children as to their family and origins. Many adopted children need special help and attention to reassure them of their status. Adolescence can be an unsettled time for any child, and adopted youngsters prove no exception. The effort of achieving adulthood can produce natural probings into who-am-I and how-is-it-that-I-am-often-at-odds-with-those-who-should-be-closest-to-me. The time of marriage and parenthood are highly significant to an adopted person and their family may well wish for some special help during those times. Typically, agencies and families have long severed their relationships by these times. But it seems more desirable to establish a strong and early relationship which will permit and even encourage contacts during these significant times.

The placement worker who has encouraged the family to establish an open and honest relationship must be emotionally prepared for the stress and strain which accompanies the family encountering difficulties. Worker panic is typical, but the realization that <u>all</u> families, including adoptive families, have crises, as well as the realization that stress and strain is an experience common to most workers dealing with the normal ambivalence of families, will make the situation more tolerable.

Most of the placement worker's efforts are seemingly geared to helping families (which, beyond placement, include parents <u>and</u> child) sort out the "adoption problems" from the "child problems." But that can be a difficult task when crisis seems everywhere at hand. The worker's ability to provide genuine confidence in the family's ability to meet the crisis and overcome it is crucial. Also crucial is the talent for listening carefully, gaining a balanced perspective, then helping the family sort through the difficulties, assign priorities, and undertake a suitable solution.

ADOPTION DISRUPTIONS

To workers committed to bringing children and parents together, a "broken" or disrupted adoption can be a demoralizing, even a depressing experience. One fact is clear. When placing older and handicapped children, the rate of disruption increases dramatically. When infants are placed for adoption, disruption usually occurs because parents fail to adjust. When older and handicapped children are involved, disruption occurs not only because parents fail to adjust, but because the child and the family fail to make crucial adjustments to the seriously damaging experiences the child brings with him into the placement. At Spaulding, our disruption rate going back six years stands at about 10 percent. Of those youngsters, all except two were placed with another family. (One teenager learned that he did not want adoption; one younger boy finally convinced all parties that he could not manage close family relationships.) Most of our children who experienced a disruption were moved to a second adoptive home directly from the first adoptive home. Adoption is like marriage: some thrive, some survive, some break up. We must prepare ourselves to accept certain risks if a maximum number of waiting children are to have the opportunity of permanent placement with a family of their own.

Knowing the child before placement through a composite evaluation would help minimize disruptions. So would the early establishment of an open and honest relationship with the adoptive family. This would permit the family and worker to concentrate on problem areas together. But despite those best efforts, some adoptions will not work out and the stress may become so severe that termination of the placement is in order. How to handle that situation? What will become of the child? What will become of the family? What can the worker do to alleviate the guilt and depression that accompanies such a decision? How can the worker survive the experience?

The attitude of the worker is crucial. A positive attitude that the situation does not mean failure for all concerned is imperative. Disruption should not come as a surprise to any worker who has been involved in regular post-placement services. It is most often the final action which follows a series of differences or problems. In adoption the worker must be able to help the family understand the normal ambivalence they feel toward almost any child, to point out the absence of the earliest possible emotional relationship, to highlight the potential frustrations of living closely with a child damaged by the necessity of separation from his biological family. But even beyond that, the worker must be able to understand that some families will learn that they cannot live with a given child, or that a particular youngster may not be able to make the kind of relationship demanded by a particular family, or that mis-judgments of the child's functioning or of the family's abilities make continuation of the placement impossible. If disruption can become yet another step in the process of resolving the future of the child, then all concerned can look at the experience differently. The worker can gain a more accurate understanding of the child. The family can come to grips with those areas where they can help a child move toward a family relationship and those areas where they cannot. The child can deal with his pain if he has the support of worker and family and the assurance that he too can learn from this experience and work toward another family placement.

Many workers panic at the appearance of any problem in an adoption. Still more workers panic at the mention of disrupting an adoption. Yet many disruptions are actually in the best interest of the child and family. It is hard for the worker to accept that in view of the difficult work ahead. The worker's task is to help the family and child understand clearly and honestly why disruption is the best plan available. The anger, guilt, and frustration must surface. But the worker's ability to provide the calm assurance that the final result of the decision will be more satisfactory for all parties is a key element.

The worker must be prepared to help both child and family continue having positive feelings about themselves. The necessity to disrupt the placement usually becomes clear by reviewing the history of the placement with the family and/or child. Understanding the necessity of disruption is important. So is sharing the responsibility of the decision. (It is a logical and mutual conclusion, not an exercise in blame assignment.) The family will usually need the worker's help in explaining their feelings to the youngster. The youngster often needs similar help from the worker. All parties will need opportunity to sift the decision more than once. The situation must be handled with great sympathy for the child's position, but faith in a better relationship ahead. For many children, return to a former foster home simply signals failure and embarrassment. (It may also signal the worker's lack of confidence in him as a child wanted by another adoptive family. In some agencies, it may also mean submerging him into a system of benign neglect where we give him "time to heal" that lasts forever.)

The worker's role with the family should continue through and beyond the actual moving of the child. They will need support in their decision and opportunities to learn how to handle this situation with other children in the family, with relatives, friends, and neighbors. They will also need help in determining if another adoption is practical or possible. (Two of our families who experienced disruption later adopted another child from us. Both placements have been very successful.)

It is our conviction that social workers can only survive disruptions if they understand them as a normal part of the placement experience. We moved to a "team concept" of supervision four years ago and discovered that since placement decisions were always and only made by the team, disruptions no longer had such profound, depressive impact on the individual worker. The fact that the team concept also provided a device for the individual worker to ask for and receive the assistance of a team member in evaluating a puzzling child or preparing a particular family has permitted us to view the disruption experience with a clear conscience. We have done what we can to reduce the possibility of worker error or family misperception. We still work on helping families explore their own capacities before placement, but we know that to demand iron clad guarantees is impossible. To find families for the many children who wait, we must assume recognizable risks and learn by daring.

SOME PARTICULAR CHILDREN

Marty

Marty was almost five when he was referred to Spaulding for placement. An unusually handsome little boy, he had been called "a confusing charmer" by his worker. He had Cerebral Palsy which has substantially weakened the left side of his body and the muscles in his throat and mouth. (Cerebral Palsy results from damage to the brain or nervous system before, during, or after birth.) Marty seemed healthy at birth and was released for adoption by his mother at three weeks of age. At five months his adoptive family began to notice that he fell to the left when propped in a sitting position. By a year, he had just learned to sit unsupported, pull himself up and crawl. He used only the right hand in reaching for things. His parents became alarmed and began taking him to a series of doctors. They received a diagnosis of Cerebral Palsy and some degree of retardation. Though the family had become very attached to Marty, they felt they could not deal with these handicaps and made the decision not to finalize the adoption. Marty then became a ward of the state.

By the time Marty was referred to Spaulding, over three years later, he was in his seventh home. His rate of development had varied from year to year according to the amount of stimulation and exercise he received from each foster family. By age four, he had made great physical gains. Although he wore a brace on his left leg at night, he was an active child who walked, ran, climbed stairs and rode bicycles. Marty's left hand remained closed and very weak. By this time, his physical problems seemed less handicapping than his slowness in social and academic areas. Marty had almost no recognizable speech, drooled almost constantly and had many difficulties chewing and swallowing food. He functioned more like a two year old than a four year old. He was given psychological tests several times. Results ranged from "serious mental retardation accompanied by an emotional component" to "this child is not seriously retarded and may be reasonably intelligent." Marty had several convulsions in his early years and an abnormal E.E.G. indicative of brain damage and possible seizure disorder. At times he was unruly and very hyperactive, while at other times he seemed calm and happy. He was a very loving child who had much to give to a family who could encourage him and yet live with the uncertainities of his future.

Our first task was to gather as much information as possible on Marty. The Spaulding worker assigned to evaluate him went to the University of Michigan Medical Library to learn about Cerebral Palsy. She then arranged to visit the child's agency and read his file. (When we read a child's file we check the legal documentation, verify birthdates, legal names, and the phraseology of Court Orders to rule out mistakes and discrepancies. We also carefully read the medical portion of the files since it is our responsibility to discuss any medical conditions with an adoptive family and we need to have as complete a picture as possible. We check to see if all follow-up work requested by the doctors has been done. We also frequently give the child's worker a list of specific questions to ask the child's doctor.) Marty's file was quite complete and contained several detailed reports from medical specialists. It was clear that no one could

predict Marty's ability to learn or to develop speech. He had been seen recently by a psychologist and was scheduled for another E.E.G. His immunizations and dental care were up to date. Our only request was another physical examination shortly before placement, to comply with our state statute.

Before talking to the foster family, we also read Marty's history for any clues of behavior patterns to anticipate in an adoptive home, situations which might be best for him, what he could give to a family, and what kinds of strengths a family would need to parent him. Armed with notes about particular areas to discuss, the Spaulding worker and Marty's worker together went to talk with the foster mother. The foster mother, prepared for their coming, seemed eager to express her own concerns and observations about Marty and the kind of family which would be best. She also seemed reassured to see the care we were taking in learning as much as possible about Marty before deciding on a family. (One of the most important and sensitive steps in the adoption process is to help the foster parents deal with their own ambivalence and concerns in coming to see this move as good for the child. If a child moves into an adoptive home with the support and approval of his foster parents, he is likely to adjust to the new family with much more ease.)

For over an hour, we asked specific questions about Marty's habits, preferences, schedule, personality traits, etc. As always, we were especially interested in how he related to various members of the family and to others. Did he show a preference for older or younger children? For men or women? What methods of discipline worked best with him? Did he like to be cuddled and by whom? Answers to these questions would help us put together a picture of the kind of family in which Marty could best function. The Spaulding worker then played and talked with Marty, finally taking several Polaroid pictures. This allowed her to observe Marty and get some intuitive feelings about him. (It is much easier and more convincing for us to talk to a potential family about a child we have met and responded to positively. If we do not respond positively to the child, as happens at some point with every worker, we might ask another Spaulding worker to meet the child and help out with recruitment efforts or transfer the child to another worker altogether. This was not necessary with Marty for he was a very appealing child and we felt that he was a loving child who could give a family many emotional rewards.) Ideally, we would try to locate a family which did not have children close in age to him. He needed a great deal of contact with children but also much individual attention and a non-competitive situation. Although we did not feel he was severely retarded, we would have to find a family who felt they could continue to accept him if he proved to be retarded. Our predominant impression was that he needed a non-pressuring family who could be content with small gains and provide a great deal of emotional warmth and support.

We had one such family waiting for a boy. They had three daughters, ages two through eleven. They seemed unusually relaxed and without rigid expectations for children. We told them everything we knew about Marty except the names and addresses of his various families. They were very interested in our information and a packet of materials furnished by the Cerebral Palsy Association. After reading this, they asked several questions about his handicaps which indicated they were doing a great deal of realistic thinking and talking. When their questions were answered they

were very interested and wanted to meet Marty. We arranged for Marty to come visit his worker's office. We had not yet told him of adoption plans as we wanted to wait until we knew we had a family for him. Marty had not been in his present foster family long, and we felt he would be more confused than helped by talk of a move. We would explain what would happen a week or two before he would be visiting the family.

After seeing Marty, the couple seemed impressed with him and felt they had done as much thinking and deciding as possible without spending more time with him. We arranged a weekend visit in their home (across the state from his foster home) to give them more time together and to introduce him to the girls. He was prepared for a visit to the family but not told of any adoption plans. However, he may well have suspected that this was going to be his next family. After one visit, the family came to a painful decision that Marty needed far more individual attention than they could reasonably give. After discussing the weekend with them, we supported this decision. (Two months later, the family adopted a ten year old boy with minor emotional problems and have been excellent parents for this child.) Although the damage to Marty could not be gauged, we felt it was to everyones' benefit that this family had been able to be honest with themselves and with us.

Because we had no other potential families, we decided to seek a family for Marty through the newspaper. We had contact with a reporter from a medium-sized city in Michigan who was doing adoption publicity. After checking educational and medical facilities for handicapped children in that area, we discovered the facilities were available and excellent. The newspaper arranged and paid for Marty's photograph to be taken by a local photographer. The reporter then interviewed both the Spaulding worker and Marty's child care worker. (In obtaining publicity, we are careful to be honest and specific in presenting the child's problems. In these articles, we do not use the word "retarded" because of its frightening implications to most people. We do however describe the child's level of functioning, his slowness to learn and his possible degree of dependence, if any, as an adult.) The article emphasized Marty's slow development in all areas but presented his slowness as more related to physical and emotional causes than to limited intelligence. We received eleven responses. Six of those families ended up adopting handicapped children through Spaulding. (Such a high percentage of families completing the process is very unusual, but may have occurred because this area of the state had barely been tapped as a resource for handicapped children. Our mentioning the fact that we charged no fee and were not looking for perfect parents with high incomes may also have encouraged people to call who might otherwise have believed they would never be allowed to adopt.)

One family who called about Marty had applied to Spaulding within the month and were in the earliest stages of the process. Their married daughter had read a newspaper article about the agency and suggested that they apply. This couple, Donald and Mary, were in their forties, had two married children and one daughter in high school. They had previously applied to a private adoption agency but were told they would not be eligible because Donald was paralyzed from the neck down as a result of Multiple Sclerosis. He had a very adequate income from Social Security and the Veteran's Ad-

ministration. (Because his illness was diagnosed shortly after leaving the service, he received a 100 percent disability payment.) They were experienced parents who enjoyed being parents and missed having young children at home. They also had contact with children in institutions and knew how damaging numerous moves could be for a child. They were interested in adopting children with major physical or mental handicaps because of their familiarity with handicaps and their realistic appraisal of a handicapped child's opportunities for adoption. Between their fear of being turned down, their non-verbalness and the worker's discomfort in talking about Donald's condition, the first interview was difficult for everyone. By the second interview when all parties had relaxed, the worker began to see them as a good family for a handicapped child such as Marty. They seemed accepting of children and committed to adoption. Their marriage was solid. Their teenage daughter was quite mature, close to her parents, and very interested in having younger brothers and sisters. An older brother and sister indicated willingness to rear the child should their parents die or become incapacitated. We began to assure the family that we felt the adoption of the kind of children of interest to them could be appropriately handled by our agency and that we would be willing, upon finding such a child, to take their case to the judge. We could not guarantee he would agree to placement, but as long as we felt as good about the parents as we did, we were prepared to argue with the judge if necessary. In the meantime, we talked to Donald's doctors and gathered enough information on Multiple Sclerosis to educate ourselves and the judge.

Donald and Mary attended a group meeting for adoptive couples and met another Spaulding worker who agreed that they could be good adoptive parents. We decided to talk with them about Marty. We were beginning to interview the families who responded to the publicity, but knew it would be several weeks before we could know them well enough to make a decision. Since this family would be ready sooner and seemed so appropriate we would let them decide whether they might be interested. They were familiar with handicaps and not likely to be overwhelmed by Marty's multiple problems. (There were no other young children in the family, but grandchildren and neighbors could provide contacts with other children. Above all, they seemed mature, nurturing, and accepting. The decision was made in terms of Marty's best interests, not a priority afforded the families responding to the newspaper publicity.) As soon as we told Donald and Mary of his availability, they began thinking of him as their son. The worker went through Marty's file with them, filling them in on the many pages of Marty's history. Although most people who knew Marty well felt he was not retarded, we told Donald and Mary that they needed to feel they could parent a retarded child. Again, they seemed sure they could. We discussed other problems such as Marty's frequent unruliness and his lack of speech. We also talked about the many positives that Marty had to offer, but agreed that it would be better to be as well prepared as possible to deal with Marty's handicaps. We then sent a copy of the adoption study to the agency having custody of the child. They seemed willing to trust our judgment and indicated they were willing to proceed with a showing.

The couple and their daughter met Marty in his foster home for a "blind" showing (where the child is not aware of the couple's possible interest in placement). The meeting between the adoptive parents and the foster

mother went reasonably well. After a half hour, the adoptive family, Marty, his worker and the Spaulding worker went to the local airport. Marty was somewhat hyperactive but seemed comfortable with the family. When the afternoon was over, he asked to ride back to the foster home in Donald and Mary's car. When they invited him to spend a weekend with them, he seemed interested. His worker spent a week preparing him for the visit, indicating that the people liked him and wanted to get to know him better. The following weekend they returned, spent some time with him in the foster home and then brought him to their home, which was across the state. Marty was tense and very hyperactive. The family began to see how difficult the adjustment was going to be for Marty and for them, but never waivered in their decision. Because he had so little speech, they also had to learn his ways of communicating. That weekend, they began talking to Marty about adopting him. For the next two weeks, his worker and his foster mother also talked to him a great deal about his new Mom and Dad. He had a scrapbook of pictures of the new family, their home, and their pets. He seemed understandably ambivalent at the idea of moving and increasingly clung to his foster parents.

During this period, we had filed our documentation in court and were waiting for the judge to approve the placement. He did so with very little hesitation. During the next visit of five days, Marty settled down considerably. Because of the distance between the foster home and the adoptive home, and to keep from confusing Marty, we decided to have him make the final move within a few days of the five day visit. On the day of the move, his worker picked him up and brought him to the agency office where his new family met them and took him home. Though he seemed tense and excited, he was glad to see his new family and eagerly went with them.

Donald and Mary have needed relatively little post-placement service with Marty. During the first six months, Marty became frightened when a worker visited the home but he soon began to learn that he would not be taken away again. From the beginning, the family has felt very close to him and proud of him. They are strict parents and have not had discipline problems at home, although some teachers and babysitters have been frustrated by his hyperactivity. Although his parents have never viewed him as retarded, nor have his teachers, Marty attends classes in a school for the orthopedically handicapped. Unfortunately, his lack of speech has been found to be related to poor muscle control in his mouth and throat. Therefore, Marty will continue to have major speech problems. This is, undoubtedly, his biggest handicap. He now uses his left had far more than previously. He has been with his adoptive family for nearly four years now, and seems to be a happy and relaxed child.

Jean and Kathy

In January 1971, Spaulding received a referral of two sisters. The referral was a challenge because of the age of the girls and the diagnosed retardation of the eldest. In addition, there had been sporadic long-term involvement with their biological siblings. Jean, age 14, and Kathy, age 15, had lived in many homes since being removed from parental custody because of neglect at ages four and five. An older biological sister, who was married and had provided a home for the girls for a short time, was particularly interested in keeping the family together. She arranged family gatherings at Christmas and provided transportation. Although Jean and Kathy did not seem overly dependent on these ties, they did enjoy them and saw family members about once a month while in foster care.

Prior to the official referral in January, the girls' child care worker had called us in October to see if we felt we could place the girls with an adoptive family under these conditions. Previous child care workers had talked to the girls about adoption but had accepted their answer that they wanted to stay in their present foster home (where they had been for less than a year) and retain family contacts. However, the foster family was not interested in permanent foster care. Because the girls would have to move eventually, their worker preferred a move to permanency. After the initial Spaulding contact, the Spaulding worker talked to the foster mother and the girls about adoption. The foster mother seemed supportive of such a plan. The girls were not opposed and seemed rather interested. It was reassuring to them to know they would have several visits and could not be adopted without their written consent. (Under Michigan statute, any child ten years or more must give written consent to their adoption.) At about the time of the official referral to Spaulding, the girls' worker visited their brothers and sisters, explaining the adoption plan. Surprisingly, they were not resistant to this, but felt it would assure their sisters a home and permanency for at least the next few years.

Jean, age 14, was a bright girl who was surprisingly happy and well adjusted for the amount of separation she had experienced. The girl was well liked by children and adults and able to stick up for herself. Kathy, age 15, was a slow learner who had failed in regular classes and was now making outstanding academic progress in a special education class. She consistently achieved a score in a mid-70 range of I.Q. tests, but more importantly, she functioned as an over-achiever with a strong desire to please. She was reasonably skilled in verbal and social skills and was always described as a well behaved, nice girl.

To learn more, two Spaulding workers went to the school to interview the girls' teachers. (Two Spaulding workers were assigned in this case because one was fairly new to staff and not yet experienced in how to evaluate children. With help from the other teammates however, she was to be responsible for recruiting a family and placing the girls.) They asked the teachers about the girls' academic progress, their ability to relate to peers and adults inside and outside the classroom, their work habits, etc.

As always, it was important to directly ask and then assess whether or not the teacher liked the child and saw the child as happy. All teachers emphasized how well both girls got along with people and how cooperative and rewarding both girls were to work with. Both seemed to be functioning at a level the teachers felt was consistent with their potential.

The workers met Jean and Kathy for an hour and a half at the foster home. First they talked with the foster mother about the girls' home adjustment, their likes, dislikes, and personality traits. Afterwards, the workers encouraged the girls to talk about any concerns or questions they might have. It was clear that the girls wanted to be placed together and be assured of freedom in contacting brothers and sisters. The Spaulding worker who was to find a family for them made arrangements to return, take them out, and to get to know them better. She was very impressed with the girls and saw them as very normal teenagers. In discussing the girls later at a staff meeting, we disagreed as to how many adjustment problems the girls would have in placement. Some of us who were then dealing with some very complicated teenage placements felt it was dangerous to assume that because the girls appeared so well adjusted and "normal" that they would continue this pattern in a new home. Although we remained somewhat stalemated, we served as checks and balances for each other in preparing the family and the girls for what was to come. Later, we found that the nature and frequency of problems in this placement varied dramatically from time to time.

Spaulding had recently been approached by a family interested in adopting a family group. They had been married 14 years, were childless, and wanted children very much. They had been members of the Council on Adoptable Children (an organization of adoptive and potential adoptive parents) for several months before approaching an agency. Although they had a beautiful home and more income than many of our families, they enjoyed simple family activities. Both had some experience with children and knew that adopting older children was going to be difficult. They realized they would have much more limited freedom and privacy once they adopted, yet they felt the pleasures would outweigh the frustrations.

In talking with families, we spend minimal time discussing family and marital history. Instead, we focus on talking about children, both those with whom the family is familiar and those whom Spaulding has placed. We emphasize early that our job together is not to get them approved or rejected as adoptive parents, but to decide what kinds of handicaps, problems, and personalities they can best deal with and what kinds of rewards they will need from children. The worker and the couple, Jack and Louise, came to the conclusion that they would probably not be terribly threatened in helping their adopted children deal with past memories or relationships. However, they thought they would have difficulty in dealing with a very rejecting or rebellious child. Increasingly, the worker became convinced that this was the family for Jean and Kathy. Interestingly, there was the same difference of opinion between the parents as among our staff. Jack seemed less certain that the girls would function as problem-free as they had to date. Louise was more easily convinced they would. Observing them discuss this difference convinced us that they were able to deal with problems and disagreements openly and directly. This would be important in living with teenagers.

We arranged for the parents to meet Jean and Kathy in a restaurant. Two days later, the parents decided to adopt the girls and begin visits. The Spaulding worker went to talk to the girls who were very excited and asked many questions. That weekend, she took the girls to Jack and Louise's home for a visit. This visit went extremely well and the girls decided they wanted to be adopted. This was the first of many weekend visits during the six weeks prior to legal placement. Transportation was shared by the adoptive family and both agencies. Eventually, the girls began taking the bus back and forth. The Spaulding worker remained in close contact with the girls and the family to help work out problems. Both girls remained enthused about the placement, even when they realized the family was going to set somewhat tighter controls on their activities than they desired. Though the girls were not yet asking to contact brothers and sisters, we established a procedure for contact when they were ready to do so.

During the first ten months of the adoptive placement, this family had fairly routine adjustment and parent/teen problems to solve. Because the girls had always lived with relatives or called their foster parents "aunt" and "uncle" they were surprised at the closeness and the expectation that "we are all responsible for each other." Though they both ultimately came to see this as an expression of caring, Jean especially had some difficulty giving up some of her accustomed freedom and independence. Kathy, a more conforming person, adjusted fairly easily and blossomed under the structure, encouragement, and time spent with her. As her worker said, "every day she gains more sparkle in her personality and more confidence in her own capabilities." Jean's mood swings and periodic dissatisfaction were normal for her age and were treated as such by her parents. They liked her energy and imagination even though it kept them on their toes.

Within two months of confirmation of the adoption, Jean quite unexpectedly decided she did not want to be adopted and that she wanted to leave. Ignoring the agreed way to make contact with her siblings, she left home, called her sister and got her involved in an elaborate struggle concerning parental controls. Our attempt to arbitrate differences between Jean and her adoptive parents came to naught since Jean was not interested in finding a solution and her parents, threatened by this rejection, became more rigid. Jean succeeded in manipulating everyone by saying we had promised she could still decide whether or not she wanted to be adopted by this family and now she did not. Finally, after observing that we had an epidemic of teenagers saying the same thing and creating the same crisis, we began to realize that by giving an adopted teenager the option to leave the family whenever he or she was unhappy, we were doing both the child and the family a great disservice. We began to realize that an adopted child, like any child, needs to test his or her power and limits but be assured that he will not be allowed to go too far. Therefore, we told Jean that she had given her written consent to the adoption and as long as her parents wished to remain her parents, we would not move her to another home. Yet, we all knew that we would not request confirmation of the adoption until she wanted it. Kathy, alarmed by all the talk of leaving, asked for her adoption to be confirmed on time. Although this left the parents with some fear that Jean could still reject them, it meant that the family unit was intact at least for the time being. Jean seemed satisfied with the solution and calmed down tremendously. The family went back to solving other prob-

lems and learning to live with Jean's ambivalence. The strength of relationships in this family continued to grow and no problems arose which they could not handle. As the end of the second year of placement neared, the parents signaled the worker that Jean was ready to talk about confirmation. Jean later told the worker she had decided some six months earlier and had just been waiting for someone to ask. The girls, now in their late teens, continue to do very well in this family.

COMMON HANDICAPS AND THEIR IMPLICATIONS

COMMON HANDICAPS AND THEIR IMPLICATIONS

The following is a discussion of common handicapping conditions. The consideration of age has not been included, though it is an important factor in evaluating a child for placement. While younger children are normally easier to place and to integrate into a family, it can be very difficult to predict the future of a physically or mentally handicapped infant or toddler. Therefore, it is sometimes easier to find and prepare adoptive parents for an older and handicapped child than for a very young child.

It is very evident that any worker seeking placement for a child who has a permanent handicap must become a "mini expert" with regard to the implications for child's and family's future. We have found that it is extremely important to be able to respond to the child's positives, going past the handicap and future limitations. Without a doubt physical appeal or attractiveness is very relevant to placeability.

We have learned that those handicaps which are visible (i.e. Cerebral Palsy, blindness, cleft palate, etc.) tend to be more easily understood. It is such less visible handicaps as diabetes, epilepsy, emotional disturbance, and retardation, etc., that seem to be more problematic primarily because families seem to feel they can make these conditions "go away" if they cannot be seen. The following is a brief summation of common handicaps, future implications, and a list of written material available which may be helpful to workers and parents.

1. Blindness

It seems that blindness should be self-explanatory, but there are a couple of issues to be considered. What is described as legal blindness may be very different than what is generally thought. A child may have peripheral vision (sides only), cone vision (just straight ahead), vision in one or the other eye, no night vision, etc. All have different implications for education and normal living. It is important to know that a child with even minimal vision is not as handicapped as a child with no vision.

The Association for the Blind has written information.

2. Cerebral Palsy

Cerebral Palsy is a catchall term which refers to a group of conditions resulting from brain damage (the most apparent is an inability to coordinate or control muscles). Other results may include convulsive disorders, limited general intelligence, problems in ability to think and express thoughts, and speech, hearing, and visual problems. A child with Cerebral Palsy has loss of muscle control in one or more parts of his body. Cerebral Palsy is not hereditary, but results from damage done before, during, or

shortly after birth and is often attributed to lack of oxygen to the brain. It is a permanent disability and cannot be cured. It is not a deteriorating condition if muscular activity and prescribed therapy are consistently used.

It is extremely difficult to describe the problems in evaluating a child with Cerebral Palsy because more than any other handicap it is very individualized. A crucial part of predicting the future of such an individual is in terms of his own motivation. Adding to that are the opportunities within the community for education and occupational therapy. Most children with serious limb involvement attend orthopedic schools (part of the public system) and go to Occupational Therapy and Physical Therapy as part of the curriculum.

United Cerebral Palsy Association "Cerebral Palsy" 25¢
66 East 34th Street
New York, New York 10016

Your local chapter of the March of Dimes organization will provide written materials and reference persons.

3. Cleft Palate

An individual with a Cleft Palate may have a slight disability or one which interferes permanently with functioning. A Cleft Palate results from a failure to close off the palatal processes of the upper jaw. In its mildest form, it can mean weak muscles in the back of the throat affecting speech. The more serious forms range from a "hair lip" (a split in the lip) to an open hole in the roof of the mouth, involving teeth, lip, nose, etc. The cause of Cleft Palate is unknown, but it is suspected to run in families.

Treatment for Cleft Palate is long and drawn out, and generally deals primarily with the cosmetic problems. The lip or other soft tissue is corrected in the first year of life. The palate, if repairable, is treated by the fifth year, otherwise an obturator (plastic palate-like denture) is used. Generally, long term speech therapy is required. Often, as an individual matures, more plastic surgery is needed to better define nose and lip.

The primary difficulties in dealing with a child with a serious Cleft Palate are in relation to emotional problems regarding acceptance by peers. These difficulties do not usually start until school begins. Communication may remain a problem throughout adulthood.

Little written material is available in public libraries. One needs to rely on information from oral or plastic surgeons and speech pathologists.

4. Deafness

Deafness is one of the most often overlooked handicaps primarily because of

the lack of visibility. It is important to know that emotional difficulties are often connected with deafness, more so than other handicaps. Often deaf children are mistaken for retarded children because of their responses to the world.

The degrees and causes of deafness are too detailed to list here, but many are treatable. There is usually an ability for verbal language.

Public and private educational facilities are available. It is important that education start at pre-school level.

Association for the Deaf has much information.

5. Diabetes (Juvenile)

Although diabetes mellitus is a relatively common disease, the implications make it a fairly severe handicap in evaluating a child for adoptive placement. The disease itself means a variety of problems, most commonly known is the inability of the body to tolerate sugar. When the onset of this disease occurs before age 12, it dramatically complicates the physical problems. Controlling diet, insulin, and exercise is crucial. The emotional difficulties which accompany the need for close supervision often increase the problems. The 6th and the 12th years are peak periods for emotional as well as physical problems because of the start of school and the onset of adolescence. In spite of the fact that most people consider diabetes to be a controlled disease, one must realize the long term implications of monitoring the child and structuring daily routine around his needs.

Of particular help to children with diabetes is the growing use of small group therapy (talking out feelings, etc.) and camps designed especially for diabetes. Close contact with and trust in the physician is imperative. In areas where available, children should be seen by a specialist in diabetes.

The Diabetic Association in any large city can provide additional written material and may even be able to provide contact with the family of a diabetic child. The Juvenile Diabetes Foundation provides a source of information and support for parents of diabetic children.

6. Mental Retardation

An individual is labeled mentally retarded if he performs on a psychological test below 75 I.Q. points. However, different tests measure different aspects of learning and none of the tests are "culture free." Mild retardation is equated with an I.Q. of 50 to 75, and indicates that the individual is "educable." Most children in this group can reach a third to fifth grade level of academic achievement, and should be independent in activities of daily living. Generally, those with an I.Q. greater than 65

and without severe emotional problems can be expected to achieve an independent existence as an adult. They should be able to work as unskilled or semi-skilled laborers, and assume family responsibilities. Moderate retardation implies I.Q. scores between 25 and 50 and the individual will have few significant academic achievements but will be "trainable" and can go to school primarily for training in self-care activities. The trainable individual may learn to read and write at a first grade level. Vocational placement is usually limited to employment in a sheltered workshop and supervision during adulthood is necessary.

When evaluating a retarded child for placement one must be very careful to attempt to evaluate how much environmental experience influences functioning. Children with even mild emotional problems can also function in the mildly retarded range. Imperative to accurate evaluation of any retarded child is a good physical and a good psychological examination using a variety of test devices. For a worker who is unfamiliar with retarded children of varying degrees it may be helpful to visit a school setting where "educable" and "trainable" children are taught.

Most public libraries have a large selection of books dealing with mental retardation.

7. Perceptual Handicaps or Brain-injured children

An individual is labeled brain-injured when his ability to perceive the world around him, to think about it, and to respond to it in effective ways, is damaged. Usually there are no visible signs of this problem. The injury may have occurred before, during, or after birth, can produce a wide variety of learning disabilities, and can include motor centers of the brain and central nervous system. (When it interferes with motor function it is described as Cerebral Palsy.)

Generally, a brain-injured child's behavior may include hyperactivity (which may be helped with medication), inconsistent learning patterns, distractability, and inability to make use of standard teaching techniques. Often the child will be of normal or near normal intelligence.

Unfortunately, the problems of the brain-damaged child may be so varied that it is difficult to pinpoint the problem and to provide an environment which is optimal for learning.

Physicians, psychiatrists, and psychologists are just beginning to deal with the causes, and schools are just beginning to plan for dealing with the effects. Often for parents the most difficult problem to handle is the child's difficulty in dealing with family and peers because of the erratic behavior.

National Easter Seal Foundation
2023 West Ogden Avenue
Chicago, Illinois 60612

"The Brain Injured Child" 25¢
(pamphlet)

Health Information Services
U.S. Government Printing Office
Washington, D. C. 20402

"Learning Disabilities due to Brain Dysfunction" No. 1646 20¢
(pamphlet)

Raising a Hyperactive Child by Mark A. Stewart, M.D. Harper and Row (book)

8. Spina Bifida

Spina Bifida is a birth defect which involves the nervous system. It occurs when the vertebra bony units which cover and protect the spinal cord fails to develop fully and the spinal cord fails to form into a tube and send out enough nerve fibers to the muscles below. As a result, a child may not be able to move his legs, may not feel heat, touch, or pain, and may not be able to learn bowel and bladder control. Frequently, another problem accompanies spina bifida-- hydrocephalus, which is an abnormally rapid and excessive enlargement of the head due to a fluid back-up. Usually this may be treated immediately with a shunt or tube which is inserted to drain fluid off the brain. This must be done as soon as possible, because brain damage may result from the increased pressure.

A child may have a varying degree of involvement with lower extremities. Many children are able to walk unaided. Others require braces and crutches, while still others are restricted to a wheel chair. The bowel and bladder function, but are nearly always suceptible to infection. Often, surgery is required to remove bladder, kidneys, and to close the colon. The hydrocephaly seldom causes further problems once a shunt has been properly inserted. However, early damage can result in mild or even severe retardation. Many children with spina bifida are of average or higher intelligence.

Generally, children attend schools or classes for the orthopedically handicapped if wheelchair-bound. Others may be in regular schools but receive some form of occupational or physical therapy.

The Spina Bifida Association has written material and could put a family or worker in touch with another family. Also, they have regular meetings and get togethers.

Association for Aid to Crippled Children "The Child with Spina Bifida"
345 East 46th Street
New York, New York 10017

BEST COPY AVAILABLE

RESOURCES

RESOURCES

When you hope to find an adoptive family for a waiting child, familiarize yourself with the implications of any diagnostic information available on the youngster. Now set out to learn what you might wish to know about a particular handicap if you were considering the adoption of just such a child. Usually you will have to seek out information from a variety of groups and organizations. Most of these groups will provide pamphlets and lead you to resources available in the various states and counties. But you must take the first step. Call or write them. Enlist the help of experienced adoptive families and prospective adoptive families in adding to the list of resources we can provide you as a start.

Blindness

National Federation of the Blind
218 Randolph Hotel Building, Des Moines, Iowa 50309 (515) 283-2601

Social Security Administration
(check telephone book for local office)

(Provides financial assistance to the blind.)

Wayne County Department of Social Services for the Blind
640 Temple, Detroit, Michigan 48201 (313) 256-3428

(Provides job placement, training, physical restoration, rehabilitation teaching and counseling for persons over 16 years of age and information regarding resources available locally for children under 16 years and special services such as leader dogs.)

Cerebral Palsy

United Cerebral Palsy Association, Inc.
66 East 34th Street, New York, New York 10016

Detroit Cerebral Palsy Center
10 Peterboro, Detroit, Michigan 48201 (313) TE3-4307

(Provides services either directly or through referral for clients in the tri-county area. Services include: medical care, therapy, recreation, social activities, parent guidance, psychological testing, counseling, day care, and group play experiences.)

Deafness

International Association of Parents of the Deaf
814 Thayer Avenue, Silver Spring, Maryland 20910

Educators' Guild, Detroit Day School for the Deaf
6301 Greenview, Detroit, Michigan 48228 Mr. and Mrs. Robert Physician

(Many larger cities, some counties and PTA organizations have formed parent groups for families of the deaf.)

Detroit Hearing and Speech Center
19185 Wyoming, Detroit, Michigan 48221 (313) 341-1353

(Offers educational programs, parent and professional workshops, hearing aid evaluation, otological screening, therapy and counseling to the hard-of-hearing.)

Diabetes

American Diabetes Association
18 East 48th Street, New York, New York 10017

Michigan Diabetes Association
6131 West Outer Drive, Detroit, Michigan 48235 (313) 34209333

(Disseminates scientific knowledge of diabetes to the medical profession and diabetics; discovers diabetics so they may be properly treated; promotes medical research and supports a summer camp for diabetic children.)

Juvenile Diabetes Foundation
35 N.E. 17th Street, Miami, Florida 33132

Michigan Juvenile Diabetes Foundation
1400 Kirts, Troy, Michigan 48084

(Local chapters composed mainly of parents of diabetic children raise money for research. They also offer moral support and counseling to other parents of disbetics and sponsor educational programs for the public.)

Mental Retardation

National Association for Retarded Children
2709 Avenue E. East, Arlington, Texas 76011

Michigan Association for Retarded Children
736 Michigan National Tower, Lansing, Michigan 48933 (517) 487-5426

(This group promotes general welfare and understanding of the mentally retarded, research, study and training of personnel, and assists in the formation of local chapters, coordinating their activities, information and programs.)

Wayne County Association for Retarded
701 Parkland Towers West, Dearborn, Michigan 48126 (313) 336-3900

(Serves as administrative, centralized control group for adult sheltered workshops, day training and pre-school programs for children under three years; adult recreational activities.)

Michigan Department of Public Health; Division of Services to Handicapped Children
252 Hollister Building, Lansing, Michigan 48904
(formerly the Michigan Crippled Children's Commission) (517) 373-3640

Wayne County Division of Services to Handicapped Children
1060 West Fort, Detroit, Michigan 48226 (313) 256-3682
(formerly the Wayne County branch of Michigan Crippled Children's Commission)

(Administers crippled children's act; provides medical and surgical treatment of crippled and afflicted children who have a condition that can be remedied and whose parents or guardians are financially unable to provide such service in whole or in part.)

Perceptual Handicaps or Brain-Injured

Association for Children with Learning Disabilities
2200 Brownsville Road, Pittsburgh, Pennsylvania 15210

Michigan Association for Children with Learning Disabilities
2338 North Woodward Avenue, Royal Oak, Michigan 48073 (313) 548-4455

(Some school districts have formed parent groups, much like PTA, serving as educational organizations to promote understanding, diagnosis, evaluation, professional training, facilities, and legislation to finance special education programs.)

Epilepsy Foundation of America
1828 L Street, N.W., Washington, D. C. 20036

Epilepsy Center of Michigan
10 Peterboro, Detroit, Michigan 48221 (313) 321-0105

(Serves as a research, diagnostic and information resource.)

Miscellaneous

General Information and Referral Centers
United Community Service of Metropolitan Detroit
51 West Warren, Detroit, Michigan (313) 833-3430

(These groups are often listed in the telephone directory under Community Information or Volunteer Bureaus. Many are funded by local community fund raising organizations.)

Health, Education and Welfare funded school programs

(The local county director or intermediate school district superintendent has information regarding the various specialized programs offered in their area. Examples: Titles I, III, and VI provide funds for a variety of services to handicapped children.)

Michigan Association for Emotionally Disturbed Children
668 Pallister, Detroit, Michigan 48202 (313) 873-3660

Muscular Dystrophy Associations of America, Inc.
1790 Broadway, New York, New York 10019

Muscular Dystrophy Association of America
400 West Marshall, Ferndale, Michigan 48220 (313) 399-8800

(Supports research, public education and patient services. Provides medical care and supportive services through their clinic. Serves a six county area.)

National Association for Autistic Children
621 Central Avenue, Albany, New York 12206

Wayne County Chapter of the National Society for Autistic Children
32522 Lyndon, Livonia, Michigan 48154 (313) 388-1741

(This group assists families in the car and education of their autistic children, promotes public awareness and diagnosis of autistic children, supports training and education for teachers and professionals.)

National Association for Mental Health, Inc.
1800 North Kent Street, Arlington, Virginia 22209

Michigan Society for Mental Health
27208 Southfield Road, Lathrup Village, Michigan 48076 (313) 557-6777

(Seeks to obtain continuous improvement and expansion of services for the mentally ill in state, federal, and community levels. Society holds conferences, workshops, publishes newsletter, bulletins, and pamphlets; provides referral services for treatment and information; is a source of information for professionals.)

National Cystic Fibrosis Research Foundation
3379 Peachtree Road, N.E., Atlanta, Georgia 30326

National Cystic Fibrosis Research Foundation, Metropolitan Detroit Chapter
1528 Woodward, Detroit, Michigan 48226 (313) 965-1276

(Supports research and public education, assists parents of cystic fibrosis patients to obtain equipment and drugs. Located in most counties.)

National Easter Seal Society for Crippled Children and Adults
2023 West Ogden Avenue, Chicago, Illinois 60612

Easter Seal Society of Wayne County
2545 Hyde Park Drive, Inkster, Michigan 48141 (313) PA2-3055

(Provides information, consultation and referral for physically handicapped children and adults. Services include a summer camp for children, club and recreational program for all age groups, loan equipment, assistance with transportation and payment of diagnostic fees. Centers located in the counties; handicaps served vary in each center.)

National Foundation - March of Dimes (Birth Defects)
P. O. Box 2000, White Plains, New York 10602

National Foundation - March of Dimes (Birth Defects) Metropolitan Chapter
20100 Greenfield, Detroit, Michigan 48235 (313) 864-6000

(Prevention and treatment of congential malformations or defects of body function or chemistry present at birth, through programs of research, patient care, public and professional health education. Through referral and direct aid services, provides assistance in prenatal care, genetic counseling, diagnosis and treatment, and sponsors scholarships in related health fields.)

National Kidney Disease Foundation
116 East 27th Street, New York, New York 10016

Michigan Kidney Disease Foundation
3378 Washtenaw, Ann Arbor, Michigan 48104 (313) 971-2800

(Establishes and maintains steroid-type drug banks throughout the state; provides grants for research, promotes professional, public and parent education; financed through foundation supporters a special clinic at Children's Hospital of Michigan for diagnostic and referral purposes.)

We have given you some information on what we have learned over the past several years. Hopefully you end with even more questions than when you began reading. That is a good and healthy sign. More than anything else,

we hope to leave you with a sense that this is, in most instances, a job that can be done by any reasonably sensitive and committed child welfare worker willing to learn from families, from children, from other social workers. A good friend once said that each waiting child's future is limited only by our vision of him. It can be the most rewarding and exhilarating social work experience you will have; it can also be the most exasperating. But for each child you come to know it may be the difference between waiting and belonging.